

State of West Virginia Public Employee Insurance Agency

Combining of Accrued Sick and Annual Leave Form

COMB LEAVE

Employee	Retiree Employee's Full Legal Name (Last) (First) (MI)	Social Security Number
	Retired Employee's Agency	Agency Account Number
	Retired Employee's Full Legal Name (Last) (First) (MI)	Social Security Number
	Retired Employee's Agency	Agency Account Number

Coverage	Coverage Selection Please indicate which retired employee will carry the : Family Health Print the name _____ Basic Life Insurance Only The premiums for the Basic Life Insurance will be deducted from monthly annuity. Print the name _____
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Signature	I hereby certify that to the best of my knowledge, the information contained herein is accurate and that providing false information on this form is illegal and those who provide false information may be prosecuted.	
	Policyholder's Signature:	Date:
	Policyholder's Signature:	Date: